101 CMR: EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

101 CMR 512.00: NURSING FACILITY USER FEES

Section

512.01: General Provisions

(1) Scope and Purpose. 101 CMR 512.00 governs the collection of nursing facility user fees.

(2) Authority. 101 CMR 512.00 is adopted pursuant to M.G.L. c. 118E.

(3) Effective Date. 101 CMR 512.00 is effective on October 6, 2016.

512.02: Definitions

As used in 101 CMR 512.00, unless the context otherwise requires, terms have the following meanings.

Assessment. The total payment due each quarter for each non-Medicare patient day, as set forth in 101 CMR 512.00.

Centers for Medicare and Medicaid Services (CMS). The federal agency under the U.S. Department of Health and Human Services that is responsible for administering the Medicare and Medicaid programs.

Continuing Care Retirement Community (CCRC). A community that furnishes board and lodging together with nursing services, medical services, or other health-related services, regardless of whether or not the lodging and services are provided at the same location, to individuals, other than those related by consanguinity or affinity to the person furnishing such care, pursuant to a contract effective for the life of the individual or for a period in excess of one year, and that has filed disclosure information with the Massachusetts Executive Office of Elder Affairs pursuant to M.G.L. c. 93, § 76(e). Licensed nursing facility beds not under the direct control of the board of the CCRC are not considered part of the CCRC.

Department of Public Health (DPH). An agency of the Commonwealth of Massachusetts, established under M.G.L. c. 17, § 1.

Executive Office of Health and Human Services (EOHHS). The executive department of the Commonwealth of Massachusetts established under M.G.L. c. 6A, § 2 that, through the Department of Elder Affairs and other agencies within EOHHS, as appropriate, operates and administers the programs of medical assistance and medical benefits under M.G.L. c. 118E and that serves as the single state agency under section 1902(a)(5) of the Social Security Act.

Facility. A nursing facility licensed by DPH under M.G.L. c. 111, § 71, including nursing or convalescent homes, an infirmary maintained in a town, a charitable home for the aged, and transitional care units.

Fiscal Year (FY). The state fiscal year from July 1st through June 30th.

Integrated Care Organization (ICO). An organization with a comprehensive network of medical, behavioral-health care, and long-term services and supports providers that integrates all components of care, either directly or through subcontracts, and has contracted with EOHHS and CMS and has been designated as an ICO to provide services to dual eligible individuals under M.G.L. c. 118E. ICOs are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services.

MassHealth Program (MassHealth). The medical assistance benefits plans operated and administered by EOHHS pursuant to M.G.L. c. 118E, § 1 *et seq.* and 42 U.S.C. § 1396 *et seq.* Title XXI of the Social Security Act (42 U.S.C. 1397), and other applicable laws and waivers to provide and pay for medical services to eligible members (Medicaid).

Medicaid Bed Day. A patient day for which the primary payer is either MassHealth or a non-Massachusetts Medicaid program, including patient days paid for by a Senior Care Organization (SCO), One Care, and the Program for All-Inclusive Care for the Elderly (PACE). Medicaid bed days include patient days of individuals who elect hospice care for which Medicaid pays for room and board.

Medicare. The federal health insurance program for people who are 65 years of age or older, certain younger people with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD) established by Title XVIII of the Social Security Act.

Medicare Patient Day. A patient day covered by Medicare Part A under either an indemnity fee-for-service arrangement or a Medicare managed care plan.

Patient Day. A day of care provided to an individual by a facility regardless of whether or not the facility has been paid for the day. The date an individual is admitted to the facility is a patient day. The date an individual is discharged is not a patient day, unless the individual is admitted and discharged on the same day. Patient days do not include the days of care for individuals who received residential care in beds licensed by DPH as level IV residential care beds. Patient days include days for which a facility reserves a vacant bed for an individual temporarily placed in a different care situation, pursuant to an agreement between the provider and the MassHealth agency.

Program of All-Inclusive Care for the Elderly (PACE). A comprehensive service delivery and financing model that integrates medical and long-term services and supports (LTSS) under dual capitation agreements with Medicare and Medicaid as described under federal regulations for PACE at 42 CFR 460. The PACE program is open to eligible MassHealth members 55 years of age and older who meet MassHealth's skilled-nursing-facility level of care criteria and reside in a PACE service area.

Residential Care. The minimum basic care and services and protective supervision required by DPH in accordance with 105 CMR 150.000: *Licensing of Long-term Care Facilities* for residents who do not routinely require nursing or other medically related services.

Residential Care Facility (RCF). A nursing facility licensed by DPH in which more than 50% of the licensed beds are designated as residential care (level IV) beds.

Senior Care Organization (SCO). An organization that participates in MassHealth under a contract with the MassHealth agency and the Centers for Medicare & Medicaid Services (CMS) to provide a comprehensive network of medical, health-care, and social-service providers and that integrates components of care, either directly or through subcontracts. Senior Care Organizations are responsible for providing enrollees with the full continuum of Medicare- and MassHealth covered services.

512.03: Facility Groups

(1) Nursing facility user fee payment liability will vary by facility group. The four groups of facilities for purposes of this regulation are defined as follows:

(a) Group I: All facilities that do not meet the criteria for group II, III, or IV;

(b) Group II: Non-profit continuing care retirement communities and non-profit residential care facilities;

(c) Group III: Non-profit facilities that participate in the Medicaid program and that provided more than 48,000 annual Medicaid bed days in state fiscal year 2015; and

(d) Group IV: Non-pediatric facilities not otherwise eligible for group II or III that

1. are located in Barnstable, Franklin, Middlesex, Norfolk, or Plymouth counties;
2. had 125 or fewer operating beds as of March 11, 2016; and
3. have a Medicaid utilization rate of less than 10% or greater than 90%, as determined by EOHHS.

(2) New facilities that come into operation subsequent to the effective date of EOHHS's approved waiver under 42 CFR 433.68(e), or facilities otherwise not included in the approved waiver application, will be considered group I facilities until EOHHS determines the facility's group eligibility. Facilities that undergo a change in status that alters their group eligibility subsequent to the effective date of this regulation will remain in their original group until EOHHS determines eligibility. If the determination of eligibility for a new facility or a facility's change in status would result in noncompliance with EOHHS's approved federal waiver, the facility will remain in its current group until such time as EOHHS is able to amend its approved waiver.

512.04: Calculation of User Fee

(1) EOHHS or its designee calculates the *per diem* user fee annually. The user fee is calculated by determining an amount (X), such that

(a) the number of expected non-Medicare patient days in group I facilities times (X), plus

(b) the number of expected non-Medicare patient days in group II and group III facilities combined, times (0.1), times (X), equals

(c) the total amount of revenue to be collected as determined by the General Court for each fiscal year.

(2) Effective October 6, 2016, the user fee will be applied as follows.

Facility Group	Per Diem User Fee
Group I	$22.22
Group II	$2.22
Group III	$2.22
Group IV	$0.00

(3) If, during the course of the fiscal year, EOHHS determines that the total amount of user fee revenue will be significantly different than previously estimated, it may recalculate the user fee and may change the user fee prospectively by administrative bulletin to reflect such changes based on the methodology described above.

512.05: Payment of User Fee

(1) Quarterly Assessment. Each facility must pay a quarterly assessment to EOHHS. Each facility must determine the amount of the assessment owed for each quarter by multiplying (1) its total non-Medicare patient days by (2) the *per diem* user fee established by EOHHS.

(2) User Fee Form. Each facility must submit its quarterly assessment on a form prepared by EOHHS. Each facility must report quarterly its total patient days by payer and its non-Medicare patient days on the user fee form. Even if the facility has not received the user fee form that does not stay the facility's obligation to remit the user fee. Facilities in group IV that have no user fee payment liability must still report their total patient days by payer and non-Medicare patient days by submitting the user fee form.

(3) Due Date.

(a) Assessment payments and the user fee form are due according to the following schedule.

Assessment Period	Payment and Form Due Date
July 1st – September 30th	November 1st
October 1st– December 31st	February 1st
January 1st – March 31st	May 1st
April 1st – June 30th	August 1st

(b) If a facility closes, it must pay any outstanding user fee obligations within 30 days of the date of closure.

(4) Administration. EOHHS will inform facilities by administrative bulletin of the procedures for the payment and collection of the user fee. EOHHS may update these procedures by administrative bulletin.

(5) Interest and Late Fees. EOHHS may assess interest and late fees on unpaid liabilities. If a facility fails to remit an assessment by the due date, EOHHS will assess interest at up to 1.5% per month on the outstanding balance and calculate the interest from the due date. EOHHS may also impose a late fee of up to 5% per month of the outstanding balance.

(6) Assessment Revenue. The total amount of assessments collected, any federal financial participation generated from the payments to facilities based on the collected assessments, penalties, and any interest earned will be credited to the general fund of the Commonwealth of Massachusetts.

(7) Enforcement Provisions. In addition to interest and late fees imposed pursuant to 101 CMR 512.05(5), EOHHS may notify DPH if a facility fails to pay a required assessment. Under the statute, DPH will revoke licensure of a facility that fails to pay a delinquent assessment.

512.06: Reporting Requirements

(1) General. Each facility must file or make available information that is required or that EOHHS deems reasonably necessary for calculating and collecting the user fee.

(2) Required Reports. Each facility must file required reports and forms with EOHHS or its designee and must submit any additional documentation requested by EOHHS or its designee to verify the accuracy of the data submitted.

(3) Audit. EOHHS or its designee may inspect and copy the records of a facility for purposes of auditing its calculation of the assessment.

(a) If EOHHS or its designee determines that a facility has either overpaid or underpaid the assessment, it will notify the facility of the amount due or refund the overpayment.

(b) EOHHS or its designee may offset overpayments against amounts due EOHHS for the assessment.

(c) If a facility is aggrieved by a decision of EOHHS or its designee as to the amount due, it may file an appeal to the Division of Administrative Law Appeals within 60 days of the date of the notice of underpayment or the date the notice is received, whichever is later. The filing of an appeal will not toll the collection of interest and penalties.

(4) Penalties. EOHHS may impose a *per diem* penalty of $100 per day if a facility fails to submit required reports or furnish other documentation requested under 101 CMR 512.00 by the dates specified in 101 CMR 512.05(3) or as specified by EOHHS in administrative bulletins or other written issuances.

512.07: Other Provisions

(1) Severability. The provisions of 101 CMR 512.00 are severable. If any provision or the application of any provision is held to be invalid or unconstitutional, such invalidity will not be construed to affect the validity or constitutionality of any remaining provisions of 101 CMR 512.00 or the application of such provisions.

(2) Administrative Bulletins. EOHHS may issue administrative bulletins to clarify policies, update administrative requirements and specify information and documentation necessary to comply with 101 CMR 512.00.

REGULATORY AUTHORITY

101 CMR 512.00: M.G.L. c. 118E.